

tion in medication. I have used cod-liver oil, properly emulsified, so as to render it palatable, and I am sure that it has built up the health of certain patients.

I wish to thank Dr. Jacobs, Dr. Day, Dr. Stevens, and Dr. Crane for their good discussions.

**Spinal Drainage: Value in the Treatment of Early Poliomyelitis**—The data gathered by J. C. Montgomery and W. C. C. Cole, Detroit (Journal A. M. A.), in twenty-six cases of poliomyelitis strongly suggest a possible beneficial effect on the outcome of the disease to be derived from early and repeated subarachnoid drainage. Vomiting was noted as the predominating initial symptom. Fever was the symptom complained of in thirteen cases. Headache was noted relatively rarely, although at some time during the course of the disease it was present in 70 per cent. Pain was noted in only 54 per cent. Fever occurred in every instance, and vomiting was noted in 60 per cent of the cases. Some redness or injection of the tonsils or pharynx was noted in practically every instance and persisted from one to two weeks after the onset of the illness. This was a matter of varying intensity; in some cases there was only a mild redness and in others a severe angina, the hyperemic area extending up into the nasopharynx, where a grayish-white exudate was almost invariably seen. Hyperesthesia was noted in every instance, although it, too, varied considerably in its intensity. Irritability was observed in about one-half the cases, although it was somewhat more constantly present in the early ones. Of the clinical signs, aside from hyperesthesia and pharyngitis, those most constantly present were neck rigidity and resistance to anterior flexion of the spine, these signs being found in 92 per cent of all cases, or in all but two. The reflexes were most unproductive of information in early cases. They were found normal, exaggerated, sluggish and, absent. The most that could be learned from them was that only in rare instances were they normal, and in one or two instances a difference between the two sides was of some help in arriving at a diagnosis. In two cases erythema of the face and neck was noted, and in one instance a definite punctate scarlatiniform eruption was present over the chest and back. This rash was so suggestive of scarlet fever that such a diagnosis was held probable, particularly in view of the severe angina that was present, and the absence of meningeal irritation. It was only when paralysis occurred that the true nature of the illness was recognized. Estimates of spinal fluid pressure were based on experience regarding rate of flow. While the pressure apparently varied in its intensity, nevertheless it was definitely increased in every instance except two, and these were beyond the acute stage. Similarly, the amount of fluid was increased in every instance except one. The degree of pleocytosis varied from 10 to 800. In some instances, when puncture was performed in the extremely early stage, practically no increase was detectable. It was a frequent experience that the cell count was higher on the second, third and fourth days of meningeal invasion than on the first day, even in the face of definite improvement symptomatically. This led to the conclusion that in those instances in which an extremely large amount of spinal fluid under great pressure is found, a cell count of 10 or 15 should be regarded, in a child at least, as a definite increase. It seems logical to assume that this low count at the first puncture may partially be explained on the basis of dilution. It has been the authors' practice, as soon as a diagnosis of poliomyelitis was suspected, to perform a lumbar puncture. If this showed definite increase in pressure, with or without a pleocytosis, it was repeated at twelve or twenty-four hour intervals until the pressure had definitely subsided. This usually occurred in about three or four punctures, and it was the usual experience that after pressure had once subsided it did not recur.

From the present study of the data supplied by the school districts it is estimated that about 12 per cent represents the amount of defective vision found among school children in the United States under the present methods of examination.—National Committee for the Prevention of Blindness.

## Clinical Notes and Case Reports

### ALLERGIC DERMATITIS

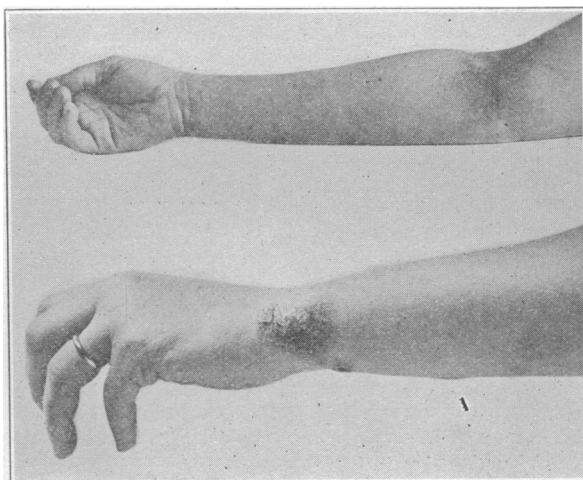
REPORT OF A CASE DUE TO MOHAIR

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Mrs. E. C. L., age 32, came to us May 26, 1925, complaining of an eczema which had for two years affected both forearms. The lesions when they first appeared had had a marked weeping tendency, but at this time were dry and scaly. Itching was a marked feature. The distribution of the lesions is shown in the accompanying unretouched photograph. At no time had lesions appeared on any other part of the body.

The condition had been treated previously by means of the lotions, ointments, and diets commonly prescribed by dermatologists. At one time the patient had for four months not allowed water to touch her forearms. The use of x-ray had served to control the weeping tendency, but had really benefitted the condition very little.

There was a positive history of allergy. The patient's mother had had hay-fever as a child. The patient her-



self had had hay-fever in her youth while a resident of Ohio. Her one child, 10 months old, had had eczematous lesions at the age of 3 months.

Food-testing by the cutaneous scratch method revealed only delayed reactions to raspberry, apricot, and banana, which reactions we felt were probably without significance. Tests with animal emanation proteins revealed immediate positive reactions to goose feathers, cattle hair, horse hair, dog hair, rabbit fur, sheep wool, and a marked reaction to goat hair.

The marked reaction to goat hair led to careful questioning as to contact with mohair. The patient then remembered that she had received a mohair upholstered overstuffed chair on January 25, 1923, that her eczema first appeared the first week of February following, and that the only period of improvement she had had was six weeks spent away from home.

Our instructions were to remove this chair from her home and to avoid allowing her skin to come in contact with any mohair, animal fur or wool. Improvement began about June 15 and continued uninterruptedly to the complete disappearance of the lesions, despite the fact that she had gone to the beach and was bathing in salt water every day. Her arms have now been entirely free

from lesions for one month. We do not deem it advisable to subject patients to a series of injections for desensitization when an exclusion therapy is so simple and so highly successful.

#### COMMENT

This case is illustrative of a very important group of dermatoses due to protein sensitization. Some few of these may perhaps be solved clinically, but in most, as in the present instance, the essential information will be withheld until the results of protein skin-testing have given the proper direction to the questioning. The patient is seldom able to associate his trouble with its cause. The only safe rule is to insist on complete and thorough protein skin-testing in all cases of unexplained or refractory dermatitis. If there is a positive history of allergy, skin testing is imperative. Positive reactions point the way to a specific therapy. In no field of medicine are results more spectacular or patients more grateful.

### USEFUL APPLIANCES IN THE TREATMENT OF SOME COMMON INJURIES

By HARRY M. WEGEFORTH, M.D., AND  
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*San Diego*

In treating patients with several fingers injured or infected, it is often difficult to redress them without causing considerable pain.

Having found that by using a perforated piece of celluloid

rounded off and covered with a strip of adhesive plaster. This will prevent irritation of the integument between the base of the injured finger and those adjoining it.

With this splint it is easy to apply a dressing that is both satisfactory to the patient and the surgeon, because all that is necessary, after the wound has been properly prepared, is to fold, in the form of a finger of a glove, the gauze on which ointment has been applied. If moist dressings are desired, the gauze, saturated with Dakin's solution, is applied around the finger so as not to interfere with the circulation of the blood. If continuous wet dressings are indicated, all that is necessary is for the patient to pour on the dressing, from time to time, the required amount of Dakin's solution, salt solution, or whatever solution is desired.

Among the many advantages of this method of treatment are:

1. That the splint can be easily removed and the finger exposed to the active rays of the sun or ultra-violet rays.
2. That it permits easy examination of the injured finger, without causing unnecessary pain.
3. That it lessens the danger of disturbing granulating tissue, as all that is necessary is to gently remove the wet dressings which do not adhere to the wound and replace them with new dressings, slipped over the end of the injured finger.
4. That the end of the celluloid splint projects about one-half an inch beyond the end of the finger, and thus affords protection from the danger of striking the injured part against objects.

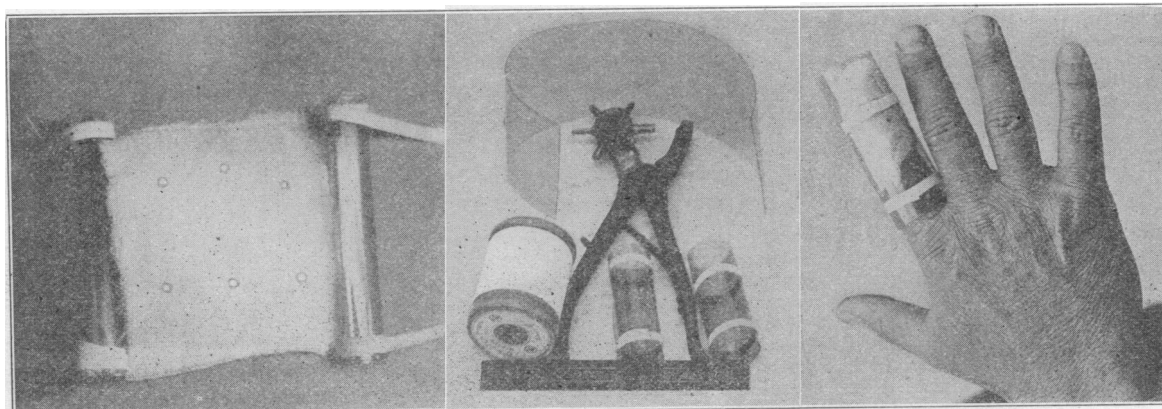


Fig. 1—The use of celluloid in the treatment of ulcers of the external abdominal wall. Fig. 2—Materials used in making a celluloid splint. Fig. 3—Application of celluloid splint to finger.

laid in treating ulcers of the abdominal wall we were able to prevent pressure on the wound and to avoid soiling of the bed clothes, we decided to apply this principle in the treatment of injuries to the fingers in order to overcome the annoying pain caused by the usual redressings and to give more satisfactory support in the case of fractures.

Ordinary celluloid, such as is used by automobile-top manufacturers, is satisfactory. Pieces are cut a little longer than the finger, overlapping about one-third of the distance. In order to avoid overheating and possible maceration of the tissues when saturated dressings are applied, the celluloid is perforated at several places by means of a harness punch.

In making a splint for the injured finger, a normal finger can be used for the purpose of shaping the celluloid. Allowances in size should be made for the type of dressings that is to be used.

The splint is retained in shape by means of pieces of adhesive plaster about one-quarter inch wide wound two or three times around the celluloid. In order to avoid the slipping of the splint, the proximal end may be perforated and the splint attached to the wrist by means of a piece of tape.

The sharp proximal ends of the splint should be

5. That in case of fracture, especially in compound fractures, the splint acts as a support for the fragments.

400 Granger Building.

**A Workman's Compensation Bill Allowed**—Recently a workman repairing automobiles was injured, and the foreman called a physician who was not employed by the insurance company that insured the automobile concern under the Workmen's Compensation Act. The physician rendered a bill to the employer of the patient who turned the bill over to the insurance company. The latter obtained a ruling from the Industrial Accident Commission, reducing the bill to about half its original amount. The question then arose as to whether the Industrial Accident Commission had the jurisdiction to reduce a physician's fees rendered unconditionally to the employer and at the employer's request. The municipal court of Boston rendered a decision in favor of the physician for the sum he claimed. The judge found that the physician was unconditionally employed by the employing corporation, which was liable for the full amount of the physician's bill.—*Journal Iowa Medical Society*.

It is more important for a doctor, no matter what character of medicine he practices, to have adequate malpractice coverage than it is to insure his automobile.